PROVIDER MANUAL

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INTRODUCTION

Welcome

Welcome to Louisiana Healthcare Connections ("LHC"). We thank you for being part of LHC network of participating physicians, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. LHC works to accomplish this goal by partnering with the providers who oversee the healthcare of LHCs' members.

About US

LHC is a Coordinated Care Network (CCN) contracted with the Louisiana Department of Health and Hospitals (DHH) to serve Louisiana members through the Medicaid program. LHC has the expertise to work with Louisiana members to improve their health status and quality of life. LHC's management company, Centene Corporation ("Centene"), has been providing comprehensive managed care services to individuals receiving benefits under Medicaid and other government-sponsored healthcare programs for more than twenty-five (25) years. Centene operates local health plans and offers a wide range of health insurance solutions to individuals and to the rising number of uninsured Americans. It also contracts with other healthcare and commercial organizations to provide specialty services. LHC is a physician-driven organization that is committed to building collaborative partnerships with providers. LHC will serve our Louisiana members consistent with our core philosophy that quality healthcare is best delivered locally.

Mission

LHC strives to provide improved health status, successful outcomes, and member and provider satisfaction in a coordinated care environment. LHC has been designed to achieve the following goals:

- Ensure access to primary and preventive care services
- Ensure care is delivered in the best setting to achieve an optimal outcome
- Improve access to all necessary healthcare services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

All of our programs, policies and procedures are designed with these goals in mind. We hope that you will assist LHC in reaching these goals and look forward to your active participation.

How to Use This Manual

LHC is committed to working with our provider community and members to provide a high level of satisfaction in delivering quality healthcare benefits. We are committed to provide comprehensive information through this Provider Manual as it relates to LHC operations, benefits, and policies and procedures to providers. Updates to this Provider Manual will be posted in LHC's web site and providers will be notified via Bulletins and notices posted in its provider secure web site and in its weekly Explanation of Payment notices. For hard copies or CD copies of this Provider Reference Manual **please contact the Provider Services department ("Provider Services") at 1-866-595-8133 or if you need further explanation on any topics discussed in the manual.**

KEY CONTACTS

The following chart includes several important telephone and fax numbers available to your office. When calling LHC, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number ("TIN") number
- Member's ID number or Medicaid ID number

Health Plan Information		
	Louisiana Healthcare Connections **Office Address** **City, State Zip** www.LouisianaHealthConnect.com	
Department	**Telephone Number**	**Fax Number**
Provider Services	1-866-595-8133	1-xxx-xxx-xxxx
Member Services	1-xxx-xxx-xxxx (TDD/TTY) 1-xxx-xxx-xxxx	1-xxx-xxx-xxxx
Authorization Request Concurrent Review Case Management	1-xxx-xxx-xxxx	1-xxx-xxx-xxxx 1-xxx-xxx-xxxx 1-xxx-xxx-xxxx
NurseWise (24/7 Availability)	1-xxx-xxx-xxxx	1-xxx-xxx-xxxx
Louisiana Department of Health and Hospitals	1-xxx-xxx-xxxx	
Medical Claims	**Reimbursement Rate Dispute**	**Medical Necessity Appeal**
Louisiana Healthcare Connections Attn: Claims PO Box 4040 Farmington, MO 63640-3826	Louisiana Healthcare Connections Attn: Claim Disputes PO Box 3000 Farmington, MO 63640-3800	Louisiana Healthcare Connections Attn: Medical Necessity Office address City State and Zip
Electronic Claims Submission		
Louisiana Healthcare Connections c/o Centene EDI Department 1-800-225-2573, ext 25525 or by e-mail to: EDIBA@centene.com		

PRODUCT SUMMARY

The population of Louisiana's Coordinated Care Network is comprised of beneficiaries whom are in a category of eligibility listed below:

Mandatory Populations

- Children under 19 years of age including those eligible under Section 1931 poverty-level related groups and optional groups of older children in the following categories
    - LIFC Program (Low Income Families with Children)
    - FITAP Program (Families in Temporary Need of Assistance)
    - CHAMP-Child Program
    - Deemed Eligible Child Program
    - Youth Aging Out of Foster Care
    - Continued Medicaid Program
    - Regular Medically Need Program
- LaCHIP Program
- Parents eligible under Section 1931 and optional caretaker relative groups including:
    - LIFC Program
    - FITAP Program
    - Continued Medicaid Program
    - Regular Medically Needy Program
- Pregnant Women
    - LaMOMS (CHAMP-Pregnant Women)
    - LaCHIP Phase IV Program
- Breast and Cervical Cancer (BCC) Program
- Aged, Blind & Disabled Adults (ABD)
    - Supplemental Security Income (SSI) Program
    - Extended Medicaid Programs
- Disabled Adult Children
- Disabled Widows/Widowers
- Early Widows/Widowers
- Pickle (ABD persons who become ineligible for SSI or MSS)
- Disabled Widows/Widowers and Disabled Surviving Divorced Spouses Unable To Perform Any Substantial Gainful Activity
- Blood Product Litigation Program
- Medicaid Purchase Plan Program
- Disability Medicaid Program

Voluntary Populations

- Native Americans who are members of federally recognized tribes except when the MCO is
    - The Indian Health Service or

    - An Indian health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service
- Children under 19 years of age who are:
    - Eligible for SSI under title XVI
    - Eligible under section 1902(e)(3) of the Act
    - In foster care or other out-of-home placement
    - Receiving foster care or adoption assistance
    - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the DHH in terms of either program participation or special health care needs or
    - Enrolled in the Family Opportunity Act Medicaid Buy-In Program

Excluded Populations

- Individual receiving hospice services
- Individuals residing in Nursing Facilities (NF) or Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
- Individuals with Medicare dual eligible
- Individuals who have been diagnosed with tuberculosis or suspected of having tuberculosis, and receiving tuberculosis-related services through the Tuberculosis Infected Individual Program
- Individuals receiving services through any 1915(c) Home and Community-Based Waiver program including but not limited to:
    - Adult Day Health Care (ADHC)
    - New Opportunities Waiver (NOW)
    - Elderly and Disabled Adult (EDA)
    - Children's Choice (CC)
    - Residential Options Waiver (ROW)
    - Supports Waiver
    - Other HCBS waivers as may be approved by CMS
- Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the Office for Citizens with Developmental Disabilities' Request for Services Registry, also knows as *Chisholm* Class Members
- Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE) a community based alternative to placement in a nursing facility that includes a complete "managed care" type of benefit combining medical, social and long-term care services
- Individual with a limited eligibility period including
    - Spend-down Medically Needy Program – an individual or family who has income in excess of the prescribed income standard
    - Emergency Services Only – emergency services for aliens who do not meet Medicaid citizenship
    - Continued Medicaid Program – short-term coverage for families who lose LIFC or TANF eligibility because of child support collections, an increase in earnings or an increase in the hours of employment

- Individuals enrolled in the LaCHIP Affordable Plan Program (LaCHIP Phase V) that provides benchmark coverage with a premium to uninsured low-income children under age 19 who do not otherwise qualify for Medicaid or other LaCHIP programs
- Individuals enrolled in and receiving Family Planning services only in the Take Charge Program which provides family planning services to uninsured women 19-44 who are not otherwise eligible for any other Medicaid program.
- Individuals enrolled in the Louisiana Health Insurance Premium Payment (LaHIPP) Program (Section 1906)

VERIFYING ELIGIBILITY

Member Eligibility Verification

To verify member eligibility, please use one of the following methods:

1. Log on to the secure provider portal at www.LouisianaHealthConnect.com. Using our secure provider website, you can check member eligibility. You can search by date of service and either of the following: member name and date of birth, or member Medicaid ID and date of birth.

2. Call our automated member eligibility IVR system. Call 1-866-595-8133 from any touch tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system twenty-four (24) hours a day. The automated system will prompt you to enter the member Medicaid ID and the month of service to check eligibility.

3. Call LHC Provider Services. If you cannot confirm a member's eligibility using the methods above, call our toll-free number at 1-866-595-8133. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will need the member name or member Medicaid ID to verify eligibility.

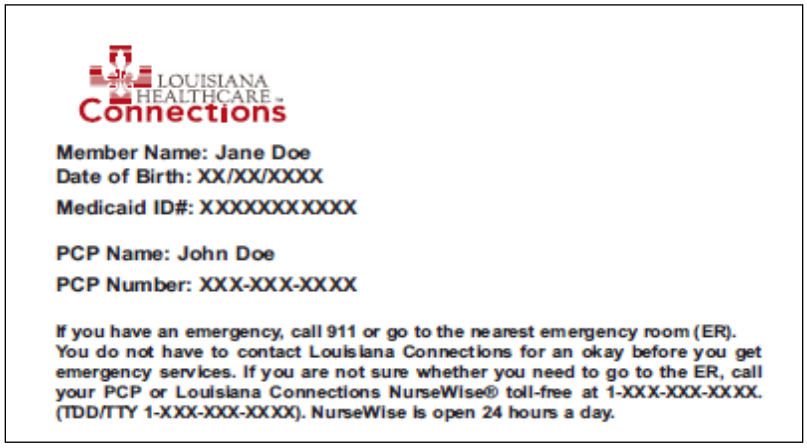
Through LHC's secure provider web portal, PCPs are able to access a list of eligible members who have selected their services or were assigned to them. The Patient list is reflective of all changes made within the last 24 hours. The list also provides other important information including date of birth and indicators for patients whose claims data show a gap in care, such as a missed Early Periodic Screening, Diagnosis and Treatment (EPSDT) exam. In order to view this list, log on to www.LouisianaHealthConnect.com. ***Since eligibility changes can occur throughout the month and the member list does not prove eligibility for benefits or guarantee coverage, please use one of the above methods to verify member eligibility on date of service.***

All new LHC members receive a LHC member ID card. Members will keep their state issued ID card to receive services not covered by the plan (such as dental, hospice and pharmacy services). A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card. **Since member ID cards**

are not a guarantee of eligibility, providers must verify members' eligibility on each date of service.

Member Identification Card

Members must present a member ID card each time services are rendered by a provider. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo identification. If you suspect fraud, please contact Provider Services at 1-866-595-8133 immediately. Members must keep the state-issued Medicaid ID card in order to receive benefits not covered by Louisiana Healthcare Connections, such as Pharmacy and Dental services.


LOUISIANA HEALTHCARE Connections

Member Name: Jane Doe
Date of Birth: XX/XX/XXXX
Medicaid ID#: XXXXXXXXXXX

PCP Name: John Doe
PCP Number: XXX-XXX-XXXX

If you have an emergency, call 911 or go to the nearest emergency room (ER). You do not have to contact Louisiana Connections for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Louisiana Connections NurseWise® toll-free at 1-XXX-XXX-XXXX. (TDD/TTY 1-XXX-XXX-XXXX). NurseWise is open 24 hours a day.


IMPORTANT TELEPHONE NUMBERS

Members:
Member Services: 1-XXX-XXX-XXXX TDD/TTY: 1-XXX-XXX-XXXX
24/7 NurseWise: 1-XXX-XXX-XXXX
Vision: 1-XXX-XXX-XXXX
File a Grievance: 1-XXX-XXX-XXXX
Report Medicaid Fraud: 1-800-488-2917

Providers:
Provider Services: 1-XXX-XXX-XXXX
IVR Eligibility inquiry - Prior Auth: 1-XXX-XXX-XXXX

Medical claims: Louisiana Healthcare Connections
Attn: CLAIMS
PO Box 4040
Farmington, MO 63640-3826

Provider/claims information via the web: www.LouisianaHealthConnect.com.

LOUISIANA HEALTHCARE CONNECTIONS WEBSITE

Louisiana Healthcare Connections Website

The LHC website can significantly reduce the number of telephone calls providers need to make to the health plan. Utilizing the website allows immediate access to current provider and member information 24 hours, seven days a week. Please contact your Provider

Relations Representative or our Provider Services department at 1-866-595-8133 with any questions or concerns regarding the website.

LHC website is located at www.LouisianaHealthConnect.com. Physicians can find the following information on the website:

- Provider Manual
- Provider Billing Manual
- Prior Authorization List
- Forms
- LHC Plan News
- Clinical Guidelines
- Provider newsletters

Secure Website

LHC web portal services allows providers to check member eligibility and benefits, submit and check status of claims, request authorizations and send messages to communicate with LHC staff. LHC contracted providers and their office staff have the opportunity to register for our **secure provider website** in just **4-easy steps**. Here, we offer tools which make obtaining and sharing information easy! It's simple and secure! Go to www.LouisianaHealthConnect.com to register. On the home page, select the Login link on the top right to start the registration process.

Through the **secure** site you can:

- Check member eligibility
- View Members' health record
- View the PCP panel (patient list)

- View and submit claims and adjustments
- View payment history
- View and submit authorizations
- View member health record
- View member gaps in care
- View quality scorecard
- Contact us securely and confidentially

We are continually updating our website with the latest news and information, so save to your Internet "Favorites" list and check our site often. Please contact a Provider Relations Representative for a tutorial on the secure site.

PRIMARY CARE PROVIDERS (PCP)

The primary care provider (PCP) is the cornerstone of LHC service delivery model. The PCP serves as the "medical home" for the member. The "medical home" concept assists in establishing a member-provider relationship, supports continuity of care, patient safety, leads to elimination of redundant services and ultimately more cost effective care and better health outcomes. LHC offers a robust network of primary care providers to ensure every member has access to a medical home within the required travel distance standards (30 miles in the rural regions and 10 miles in the urban regions). LHC requests that PCP's inform our member services department when a LHC member misses an appointment so we may monitor that in our system and provide outreach to the member on the importance of keeping appointments. This will assist our providers in reducing their missed appointments and reduce the inappropriate use of Emergency Room services.

Provider Types That May Serve As PCPs

Physicians who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, Family and General Practitioners and Nurse Practitioners. The PCP may practice in a solo or group setting or at a FQHC, RHC or outpatient clinic. LHC may allow some specialists to serve as a member's PCP for members with multiple disabilities or with acute or chronic conditions as long as the specialists is willing to perform the responsibilities of a PCP as stipulated on page 13 of this manual.

LHC will provide access to PCPs that offer extended office hours (minimum of two hours after 5:00 pm) at least one day a week and on Saturdays four hours or longer. As part of its reporting responsibilities, LHC will notify the State's enrollment broker of any PCP that will not accept new patients or who has reached member enrollment capacity.

Member Panel Capacity

All PCPs reserve the right to state the number of members they are willing to accept into their panel. LHC **DOES NOT** guarantee that any provider will receive a certain number of members.

The PCP to member ratio shall not exceed the following:

- Physicians – 1: up to 2,500
- Nurse Practitioner 1: up to 1,000

- Physician with physician extenders (Nurse Practitioner/Physician Assistant; and Certified Nurse Midwife for OB/GYNs only) may increase basic physician ratio of 1: up to 2,500 by 1,000 per extender.

These ratios apply to all CCNs and Medicaid fee for service members assigned to a PCP or extender.

If a PCP does declare a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact LHC Provider Services at 1–866-595-8133. A PCP shall not refuse to treat members as long as the physician has not reached their requested panel size.

Providers shall notify LHC in writing at least forty-five (45) days in advance of his or her inability to accept additional Medicaid covered persons under LHC agreements. In no event shall any established patient who becomes a Covered Person be considered a new patient. LHC prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

Assignment of Medical Home

Louisiana Healthcare Connections offers a robust network of primary care providers to ensure every member has access to a "medical home" within the required travel distance standards (10 miles in the urban areas and 30 miles in the rural areas).

For those members who have not selected a PCP during enrollment, LHC will use a PCP auto-assignment algorithm to assign an initial PCP. The algorithm assigns members to a PCP according to the following criteria, and in the sequence presented below:

1. Member history with a PCP. The algorithm will first look to see if the member is a returning member and attempt to match them to previous PCP. If the member is new to LHC, claim history provided by the state will be used to match a member to a PCP that the member had previous relationship where possible.

2. Family history with a PCP. If the member has no previous relationship with a PCP, the algorithm will look for a PCP that someone in the member's family, such as a sibling, is or has been assigned to.

3. Geographic proximity of PCP to member residence. The auto-assignment logic will ensure members travel no more than thirty (30) miles in the rural regions and ten (10) miles in the urban regions.

4. Appropriate PCP type. The algorithm will use age, gender, and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant moms assigned to OB/GYNs.

Pregnant women should choose a pediatrician, or other appropriate PCP, for the care of their newborn baby before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, LHC will assign one for her newborn. If LHC was not aware of that the member was pregnant until

she presented for delivery, LHC will assign a pediatrician or PCP to the newborn baby within one (1) business day after birth.

Patient Centered Medical Home Model

Louisiana Healthcare Connections (LHC) is committed to supporting its network providers in achieving recognition as Patient Centered Medical Homes (PCMH) and will promote and facilitate the capacity of primary care practices to function as medical homes by using systematic, patient-centered and coordinated care management processes. In alignment with the vision of DHHS, it is LHCs' goal to have all of its primary care providers recognized as a PCMH by an accrediting agency. LHC will support providers in obtaining either NCQA's Physician Practice Connections®-Patient-Centered Medical Home (PPC®- PCMH) recognition or the Joint Commission's Primary Care Medical Home Option for Ambulatory Care accreditation.

The purpose of the PCMH program is to promote and facilitate a medical home model of care that will provide better health care quality, improve self-management by members of their own care and reduce avoidable costs over time. LHC will actively partner with our providers, with community organizations, and groups representing our members to increase the numbers of providers who are recognized as PCMHs (or committed to becoming recognized) and who achieve the meaningful use of health information technology (HIT).

LHC has dedicated resources to ensure its providers achieve the highest level of PCMH recognition with a technical support model that will include:

- Readiness survey of contracted providers
- Education on the process of becoming certified
- Resource tools and best practices.

From an information technology perspective, we will be offering several HIT applications for our network providers who are either recognized PCMH's or are committed to becoming NCQA or Joint Commission accredited medical homes. Our secure **Provider Portal** offers tools that will help support PCMH accreditation elements. These tools include:

- Online Care Gap Notification
- Member Panel Roster including member detail information
- Trucare Service Plan
- Health Record
- Provider Overview Report

For more information on the Patient Centered Medical Home model or to how to become a PCMH, visit our web site or contact your Provider Relations Representative.

Primary Care Provider (PCP) Responsibilities

PCP's responsibilities include, but are not limited, to the following :

- Establish and maintain hospital admitting privileges sufficient to meet the needs of all linked members, or entering into formal arrangements for management of inpatient hospital admissions of members;

- Manage the medical and health care needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times including members with special needs and chronic conditions;
- Educate members on how to maintain healthy lifestyles and prevent serious illness
- Provide screening, well care and referrals to community health departments and other agencies in accordance with DHH provider requirements and public health initiatives;
- Maintain continuity of each member's health care by serving as the member's medical home;
- Offer hours of operation that are no less than the hours of operating hours offered to commercial members or comparable to commercial health plans if the PCP does not provide health services to commercial members;
- Provide referrals for specialty and subspecialty care and other medically necessary services which the PCP does not provide;
- Ensure follow-up and documentation of all referrals including services available under the State's fee for service program;
- Collaborate with LHC's case management program as appropriate to include, but not limited to, performing member screening and assessment, development of plan of care to address risks and medical needs, linking the member to other providers, medical services, residential, social, community and to other support services as needed;
- Maintain a current and complete medical record for the member in a confidential manner, including documentation of all services and referrals provided to the member, including but not limited to, services provided by the PCP, specialists, and providers of ancillary services.
- Adhere to the EPSDT periodicity schedule for members under age twenty-one (21);
- Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization; as well as coordinating services the member is receiving from another health plan during transition of care;
- Share the results of identification and assessment for any member with special health care needs with another health plan to which a member may be transitioning or has transitioned so that those services are not duplicated; and
- Actively participate in and cooperate with all LHC quality initiatives and programs.

Referrals

It is LHC preference that the PCP coordinates healthcare services. However, members are allowed to self-refer for certain services (see below). PCPs are encouraged to refer a member when medically necessary care is needed that is beyond the scope of the PCP. Paper referrals are not required. The PCP must obtain prior authorization from LHC for referrals to certain specialty providers as noted on the prior authorization list. All out-of-network services require prior authorization as further described herein. A provider is also required to promptly notify LHC when prenatal care is rendered.

LHC encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better

coordinate their members' care and ensure the referred specialty physician is a participating provider within the LHC network and that the PCP is aware of the additional service request.

Providers are prohibited from making referrals for designated health services to healthcare entities with which the provider or a member of the providers' family has a financial relationship.

To verify whether an authorization is necessary or to obtain a prior authorization, call:

Louisiana Healthcare Connections
Medical Management/Authorization Department
Telephone 1-xxx-xxx-xxxx
Fax 1-xx-xxx-xxxx
www.LouisianaHealthConnect.com

Prior authorization requests may be done electronically on our Provider Portal (using the ANSI X 12N 278 transaction code specifications). For more information on filing prior authorizations electronically, or any other questions regarding the Provider Portal, please contact your Provider Relations Representative.

Self-Referrals

The following services do not require PCP authorization or referral:

- Emergency services including emergency ambulance transportation
- OB/GYN services with a participating provider
- Women's health services provided by a Federally Qualified Health Center (FQHC) or Certified Nurse Practitioner (CNP)
- Family planning services and supplies from a qualified Medicaid family planning provider
- General optometric services (preventative eye care)
- Except for emergency and family planning services, the above services must be obtained through LHC network providers.

Specialist Responsibilities

Selected specialty services require a referral from the PCP. The specialty physician may order diagnostic tests without PCP involvement by following LHC referral guidelines. The specialty physicians must abide by the prior authorization requirements when ordering diagnostic tests; however, the specialist may not refer to other specialists or admit to the hospital without the approval of a PCP, except in a true emergency situation.

Emergency admissions require certification with authorization unit within 2 business days of admission. All non-emergency inpatient admissions require prior authorization from LHC.

The specialist provider must:

- Maintain contact with the PCP

- Obtain referral or authorization from the member's PCP and/or LHC Medical Management department ("Medical Management") as needed before providing services
- Coordinate the member's care with the PCP
- Provide the PCP with consult reports and other appropriate records within five (5) business days
- Be available for or provide on-call coverage through another source twenty-four (24) hours a day for management of member care
- Maintain the confidentiality of medical information
- LHC providers should refer to their contract for complete information regarding providers' obligations and mode of reimbursement
- Actively participate in and cooperate with all LHC quality initiatives and programs.

LHC providers should refer to their contract for complete information regarding providers' obligations or contact their Provider Relations Representative.

Mainstreaming

LHC considers mainstreaming of its members an important component of the delivery of care and expects its participating providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership or physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a member a covered services or availability of a facility
- Providing an LHC member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: different waiting rooms or appointment times or days)

Appointment Accessibility Standards

LHC follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. LHC monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to first, ensure adequate appointment availability and second, reduce unnecessary emergency room utilization.

Type of Appointment	Scheduling Time Frame
Primary Care Providers	
Routine, non-urgent, or preventative care visits	Within six (6) weeks
Non-urgent sick care (including walk in patients)	Within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition
Urgent Care (including walk in patients)	Within twenty-four (24) hours
Emergent or emergency visits	Immediately upon

	presentation
Pregnant Women	
Initial prenatal visits for newly enrolled pregnant women within their first trimester	Within fourteen (14) days of the postmark date from the member's enrollment material
Initial prenatal visits for newly enrolled pregnant women within the second trimester	Within seven (7) days of the postmark date from the member's enrollment material
Initial prenatal visits for newly enrolled pregnant women within the third trimester	Within three (3) days of postmark date from the member's enrollment material
High risk pregnancies	Within three (3) days of identification of high risk by LHC or maternity care provider, or immediately if an emergency exists.
Enrollees who become pregnant	Within forty-two (42) days
Specialty Care Providers	Within one (1) month of referral or as clinically indicated
Lab and X-ray services	Not to exceed three (3) weeks for usual and customary and forty eight (48) hours for urgent care or as clinically indicated
Follow-up visits	In accordance with ER attending provider discharge instructions
In Office waiting time for scheduled appointments	Not to exceed forty-five (45) minutes – If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than ninety (90) minutes, the patient shall be offered a new appointment.

Covering Providers

PCPs and specialty physicians must arrange for coverage with another LHC network provider during scheduled or unscheduled time off. In the event of unscheduled time off, please notify Provider Relations of coverage arrangements. The covering provider must have an active Louisiana Medicaid ID number and an active NPI number in order to receive payment. If the participating physician is capitated for primary care services, compensation for the covering physician is considered to be included in the capitation payment. If the participating physician is paid a fee-for-service by LHC, the covering physician is compensated in accordance with the fee schedule in their agreement.

Telephone Arrangements

PCPs and Specialists must:

- Answer the member's telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a member
- Identify and reschedule broken and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
    - o After hours telephone care for non-emergent, symptomatic issues within thirty (30) minutes
    - o Same day for non-symptomatic concerns
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member's medical record

***Note**: If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to member receiving urgent or emergent care.*

LHC will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement program ("QIP").

24-Hour Access

LHC PCPs and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services and shall ensure that such services are accessible to members as needed twenty-four (24) hours a day, three hundred sixty-five (365) days a year as follows:

- A provider's office phone must be answered during normal business hours
- During after- hours, a provider must have arrangements for:
    - o Access to a covering physician,
    - o An answering service,
    - o Triage service, or
    - o A voice message that provides a second phone number that is answered.
    - o Any recorded message must be provided in English and Spanish.

Examples of Unacceptable After-Hours Coverage include, but are not limited to:

- The Provider's office telephone number is only answered during office hours;

- The Provider's office telephone is answered after-hours by a recording that tells patients to leave a message;
- The Provider's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and
- Returning after-hours calls outside thirty minutes.

The selected method of twenty-four (24) hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. The PCP, specialty physician, or covering medical professional must return the call within thirty (30) minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

LHC will monitor providers' offices through scheduled and un-scheduled visits conducted by LHC Provider Relations staff.

Hospital Responsibilities

LHC utilizes a network of hospitals to provide services to LHC members. Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services
- Notify LHC Medical Management department by sending an electronic file of the ER admission by the next business day. The electronic file should include the member's name, Medicaid ID, presenting symptoms/diagnosis, DOS, and member's phone number.
- Notify LHC Medical Management department of all admission within two (2) business days.
- Notify LHC Medical Management department of all newborn deliveries within two (2) days of the delivery

LHC hospitals should refer to their contract for complete information regarding the hospitals' obligations and reimbursement.

Advanced Directives

LHC is committed to ensure that its members are aware of and are able to avail themselves of their rights to execute advance directives. LHC is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

PCPs and providers delivering care to LHC members must ensure adult members eighteen (18) years of age and older receive information on advance directives and are informed of

their right to execute advance directives. Providers must document such information in the permanent medical record.

LHC recommends to its PCPs and physicians that:

- The first point of contact for the member in the PCP's office should ask if the member has executed an advance directive and the member's response should be documented in the medical record

- If the member has executed an advance directive, the first point of contact should ask the member to bring a copy of the advance directive to the PCP's office and document this request in the member's medical record

- An advance directive should be included as a part of the member's medical record and include mental health directives

If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

Voluntarily Leaving the Network

Providers must give LHC notice of voluntary termination following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to LHC or the member.

LHC will notify affected members in writing of a provider's termination, within thirty (30) calendar days of the receipt of the termination notice from the provider, provided that such notice from the provider was timely. If the terminating provider is a PCP, LHC will request that the member elect a new PCP within ten (10) business days of the postmark date of the termination of the PCP notice to members and provide information on options for selecting a new PCP. If a member does not elect a PCP prior to the provider's termination date, LHC will automatically assign one to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of sixty (60) days, the anniversary date of the member's coverage, or until LHC can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, LHC will reimburse the provider for the provision of covered services for up to ninety (90) days from the termination date. In addition, LHC will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

Exceptions may include:

- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept payment from LHC

LHC will also provide written notice to a member within thirty (30) days, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable.

CULTURAL COMPETENCY

Cultural competency within LHC is defined as "the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused and family oriented. In particular, it is the promotion of quality services to understand, racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner."

LHC is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

LHC as part of its credentialing will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist provider's in developing culturally competent and culturally proficient practices.

Network providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them
- Medical care is provided with consideration of the members' race/ethnicity and language and its impact/influence on the members' health or illness
- Office staff that routinely interact with members have access to and participate in cultural competency training and development
- Office staff that is responsible for data collection makes reasonable attempts to collect race and language specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children
- Treatment plans are developed with consideration of the members race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on healthcare

- Office sites have posted and printed materials in English and Spanish, and if required by DHH, any other required non-English language.

BENEFIT EXPLANATION AND LIMITATIONS

Louisiana Healthcare Connections Health Plan Benefits

LHC network providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this provider manual, please contact Provider Services at 1-866-595-8133 from 7:00 a.m. to 7:00 p.m. (CST) Monday through Friday. A Provider Services Representative will assist you in understanding the benefits.

LHC covers, at a minimum, those core benefits and services specified in our Agreement with DHH and are defined in the Louisiana Medical State Plan, administrative rules, and Department policies and procedure manual.

DRAFT

Benefits and Services Requiring Plan Authorization

This list is not intended to be an all-inclusive list of covered services but it substantially provides current PA instructions. All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. All Out of Network services require prior authorization, excluding emergency and family planning services.

Service	Benefit Limitation	Prior Authorization	Comments
Abortion (Elective)	Covered only when medically necessary to save the life of the mother or if pregnancy is the result of rape or incest.	No	*Must submit Louisiana Medicaid Abortion Necessity Form with Claim.*
Acute medical detoxification		**See Comments**	**Prior authorization required** for Elective/Scheduled admissions. Urgent/Emergent admissions require notification within 2 business days.
Ambulance - Airplane		**Yes**	**Prior authorization required** for Fixed Wing (airplane) Ambulance

Service	Benefit Limitation	Prior Authorization	Comments
			Services
Ambulance – Emergent		No	Includes emergency ground and emergency helicopter ambulance
Ambulatory Surgery Center		No	Except as otherwise noted on this list.
Basic Behavioral Health Services	Limited to services performed in PCP or medical office	**No**	Screening, prevention, early intervention, medication management, and referral services
Cardiac Rehab Services		**Yes**	
Chiropractic Services	For members less than 21 years old	**Yes**	**Prior authorization required**
Cochlear Implants		**Yes**	**Prior authorization required** for cochlear implants (L8627-L8629; L8691). Batteries do not require authorization.
Communicable Disease Services		No	
Dental - General Anesthesia		**Yes**	**Prior authorization required**
Dental – Emergency, Medical/Surgical	**Routine and preventive dental services are not covered by LHC**	**See Comment**	Services performed by an oral surgeon require prior authorization as noted below. Routine/preventive dental is covered by Louisiana Medicaid.
Dialysis		No	Includes free standing and outpatient hospital setting
Durable Medical Equipment (DME)	For members less than 21 years old	**See Comments**	**Prior authorization required** for the following items: • Apnea Monitor • Bi-pap • Bili-Lights • Bone Growth Stimulator • C-pap • Hearing Aids

Service	Benefit Limitation	Prior Authorization	Comments
			• Neuro Stimulator • Wound Vacuum • Rental Items with purchase price ≥ $500 • Rental items with rental ≥ $250 if no purchase price • Purchase Items with price≥ $500
Early Periodic Screening Diagnosis and Treatment	For members less than 21 years old	No	EPSDT/ well child services
Emergency Room Services (Under 21 years old and Pregnant Women)	None	No	
Emergency Room Services (Non Pregnant Adults)	Non-pregnant adults limited to 3 visits per year	**No**	
Enteral & Parenteral Nutrition for Home Use		**Yes**	**Prior authorization required**
Family Planning	Includes well woman exams, screenings, pregnancy testing, prescription birth control pills, Mirena, and other Intra-Uterine Devices (IUDs).	No	Services may be provided by out of network provided.
FQHC & RHC Services		No	
Genetic Testing		**Yes**	**Prior authorization required:** CPT codes: 83890-83898; 83900-83909; 83912-83915; 84999; 88230-88239; 88240-88249; 88261-88267 and

Service	Benefit Limitation	Prior Authorization	Comments
			select 'S' codes
Hearing Aids and Batteries	For members less than 21 years old	**See Comments**	**Prior authorization required** for hearing aids. Batteries do not require authorization.
High Tech Imaging		**Yes**	**Prior authorization required** for CT, MRA, MRI, PET Scan
Home Health Care Services		**Yes**	**Prior authorization required** for services including but not limited to: Skilled nursing services / Home health aide Home physical, occupational or speech therapy Home infusions / Wound therapy
Inpatient Hospital Services		**See Comments**	**Prior authorization required** for Elective/Scheduled admissions and rehab admissions. Urgent/Emergent admission requires notification within 2 business days.
Hysterectomy		**Yes**	**Prior authorization required**. *Must submit copy of Sterilization Consent Form*
Laboratory Services		No	Only Genetic Testing as noted above
Maternity Care Services		No	Submit Notice of Pregnancy (NOP) form at first visit.
Neuro-Psychological Services		**Yes**	**Prior authorization required** for codes: 96118, 96119, 96120
Non-Emergency Transportation		**Yes**	Services administered by [Transportation Vendor] See Page 28 for more information on this benefit
OB Ultrasound		**See Comments**	2 allowed in 9 months. **Prior authorization required for additional u/s** except if ordered by perinatologist.
Observation		**Yes**	**Prior authorization required** for hospital

Service	Benefit Limitation	Prior Authorization	Comments
			observation admission
Oral Surgeon Services		**Yes**	**Prior authorization required** for procedures conducted by Oral Surgeon
Orthotics & Prosthetics (O&P)	**For members less than 21 years old**	**See Comments**	**Prior authorization required** for purchases of $500 or greater
Out-of-Network Physician & Facility		**Yes**	**Prior authorization required for all out of network provider/facility. EXCLUDES emergency room (ER) services, family planning services, routine labs and table top x-rays**
Pain Management Services		**Yes**	**Prior authorization required** for services, including pain/nerve blocks, epidural injections, neuro-stimulators (both in office and outpatient)
Physician, Physician Assistant, and Nurse Practitioner Office Visits		No	See Out-of-Network
Plastic Surgeon		**Yes**	**Prior authorization required** for all treatments & procedures in office or outpatient setting. Services for cosmetic purposes are not a covered benefit.
Podiatrist Services		No	
Procedures/Surgery		**See Comments**	**Prior authorization required** for the following services: Bariatric surgery Blephroplasty Breast reconstruction Breast reduction Mammoplasty Otoplasty Rhinoplasty Varicose Vein treatments *All other potentially cosmetic services
Pulmonary Rehab Services		**Yes**	

Service	Benefit Limitation	Prior Authorization	Comments
Radiology and x-rays		**See Comments**	**Prior authorization required** for high-tech radiology including CT, MRI, MRA, PET. Services administered by National Imaging Associates (NIA). No PA required for routine x-rays. See OB Ultrasound.
Sleep Study		**Yes**	**Prior authorization is required** for study in outpatient or home setting
Specialty Injection and/ or Infusion Services		**See Comments**	**Prior authorization is required** for select Biopharmaceuticals. See listing on the LHC website.
Stereotactic Radiosurgery		**Yes**	**Prior authorization is required**
Sterilization Procedures		No	Must submit Sterilization Consent form with claim.
Therapy (OT, PT, ST) Services (Outpatient)	For members less than 21 years old	**Yes**	**Prior authorization required** *after Initial evaluation*. Submit treatment plan & goals for continued services. Must bill with appropriate G modifiers.
Transplant Service		**Yes**	**Prior authorization required** for all transplant services including transplant evaluation, pre and post services.
Urgent Care Center		No	Place of Service/Location = 20
Vision Services and Eyewear	**<21 years** – Exams for treatment of eye conditions including vision correction. Regular eyeglasses when they meet certain minimum strength.	See Comments	**Services administered by OptiCare.**

Service	Benefit Limitation	Prior Authorization	Comments
	Specialty eyewear or contacts w/ PA. **> 20 years** – Exams for treatment of eye conditions only. Does not cover routine eye exams for vision correction. Does not cover eyeglasses.		

Non-Emergent Medical Transportation

For medically necessary non-emergent transportation requested by the member or someone on behalf of the member, LHC will require the transportation provider to schedule transportation so that the member arrives on time but no sooner than one hour before the appointment; nor have to wait more one hour after the conclusion of the treatment for transportation home; not be picked up prior to completion of treatment. LHC requests it transportation providers to inform our Member Services department when a member misses a transportation appointment so that it can monitor and educate the member on the importance of keeping medical appointments.

NON-Covered Services:	Comments
Behavioral/Mental Health	Services performed by Behavioral Health practitioner, including inpatient psychiatric. Covered by DHH on FFS basis
Elective Abortions and Related Services	
Elective Cosmetic Surgery	
Experimental/ Investigational Services	Including drugs, procedures and equipment. Phase I & II Clinical Trials are considered experimental
Dental Care Services	Covered by DHH on FFS basis
Hospice Services	Covered by DHH on FFS basis
Infertility Treatment Services	
Institutional Long-Term Care Facilities / Nursing Homes / ICF/DD Services	Covered by DHH on FFS basis
Prescription Drugs	Includes total parenteral nutrition. Covered by DHH on FFS basis

Network Development and Maintenance

Louisiana Healthcare Connections (LHC) will ensure the provision of covered services as specified in by the State of Louisiana. Our approach to developing and managing the provider network begins with a thorough analysis and evaluation of the State of Louisiana Department of Health and Hospitals network adequacy requirements for the Coordinated Care Networks Medicaid Initiative. LHC will develop and maintain a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members, both adults and children, without excessive travel requirements, and that is in compliance with DHH's access and availability requirements.

LHC offers a network of primary care providers to ensure every member has access to a medical home within the required travel distance standards (30 miles in the rural regions and 10 miles in the urban regions). Physicians who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, Family and General Practitioners and Nurse Practitioners. (More information on Primary Care Physicians and their responsibilities can be found on page 13). In addition, LHC will have available, at a minimum, the following specialists for both adult and pediatric members on at least a referral basis:

- Allergy/Immunology
- Anesthesiology
- Chiropractic
- Dermatology
- Electro-diagnostic Medicine
- Emergency Medicine
- Family Medicine (General)
- Internal Medicine (General)
    - Internal Medicine (Subspecialties)
    - Cardiovascular Disease *
    - Endocrinology and Metabolism*
    - Gastroenterology
    - Hematology
    - Infectious Disease
    - Medical Oncology
    - Nephrology*
    - Pediatrics
    - Pulmonary Disease
    - Rheumatology
    - Geriatric Medicine
    - Intensive Critical Care
- Medical Genetics
- Nephrology
- Neurology
    - Neurological-Surgical
    - Nuclear Medicine
- Obstetrics and Gynecology
    - Maternal and Fetal Medicine

- Oncology
- Optometry
- Orthopedics*
- Osteopathy
- Otolaryngology
- Pathology
- Pediatric (General)
- Pediatric (Subspecialties)
- Cardiology
- Hematology/Oncology
- Internal Medicine
- Nephrology
- Neonatal Medicine
- Endocrinology
- Pulmonology
- Gastroenterology
- Intensive Critical Care
    - Adolescent Medicine
    - Physical Medicine and Rehabilitation
    - Psychiatry
    - Radiology
    - Respiratory/Pulmonary
- Medical Services
- Surgery (General)
- Surgery (Subspecialties)
    - Cardiac/Thoracic
    - Plastic (limited)
    - Pediatric
    - Vascular Surgery (General)
    - Surgery of the Hand
    - Surgical Critical Care

* Require both adults and pediatric providers

In the event Louisiana Connections' network is unable to provide medically necessary services required under the contract, Louisiana Connections shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances. For assistance in making a referral to a specialist or subspecialties for a LHC member, please contact our Medical Management team at XXX-XXX_XXXX and we will identify a provider to make the necessary referral.

With the use of GEO access tools, LHC will monitor its access to all specialists and will ensure that the number of LHC members per specialist does not exceed the State of Louisiana's requirements.

LHC goal is to exceed the State's minimum requirements (listed as following):

Specialty	Number of Members
Allergy & Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Urology	30,000

Tertiary Care

LHC offers a network of tertiary care inclusive of trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities and medical sub specialists available 24 hours per day in the geographical service area. In the event LHC's' network is unable to provide the necessary tertiary care services required, LHC shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

MEDICAL MANAGEMENT

Overview

LHC Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., CST (excluding holidays). After normal business hours, Nursewise staff is available to answer questions about prior authorization. Medical Management services include the areas of utilization management, case management, disease management, and quality review. The department clinical services are overseen by the LHC medical director ("Medical Director"). The VP of Medical Management has responsibility for direct supervision and operation of the department. To reach the Medical Director or VP of Medical Management contact:

Medical Management
1-xxx-xxx-xxxx
Fax 1-xxx-xxx-xxxx
www.louisianahealthconnect.com

Utilization Management

The LHC Utilization Management Program (UMP) is designed to ensure members of Louisiana Coordinated Care Network receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, and ancillary care services.

LHC UMP seeks to optimize a member's health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Our program goals include:

- Monitoring utilization patterns to guard against over- or under- utilization
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of case and/or disease management for members at risk for significant health expenses or ongoing care
- Development of an infrastructure to ensure that all LHC members establish relationships with their PCPs to obtain preventive care
- Implementation of programs that encourage preventive services and chronic condition self-management
- Creation of partnerships with members/providers to enhance cooperation and support for UMP goals

Referrals – As promoted by the Medical Home concept, PCPs should coordinate the healthcare services for LHC members. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters; however, paper referrals *are not* required. To better coordinate a members' healthcare, LHC encourages specialists to communicate to the PCP the need for a referral to another specialist rather than making such a referral themselves.

Notifications - A provider is required to promptly notify LHC when prenatal care is rendered. Early notification of pregnancy allows the health plan to assist the member with prenatal care coordination of services.

Prior Authorizations - Some services require prior authorization from LHC in order for reimbursement to be issued to the provider. All out-of-network services require prior authorization. To verify whether a prior authorization is necessary or to obtain a prior authorization, call:

Louisiana Healthcare Connections
Medical Management/Prior Authorization Department
Telephone 1-xxx-xxx-xxxx
Fax 1-xxx-xxx-xxxx
www.LouisianaHealthConnect.com

Prior Authorization requests may be done electronically following the ANSI X 12N 278 transaction code specifications. For more information on conducting these transactions electronically contact:

Louisiana Healthcare Connections
c/o Centene EDI Department
1-800-225-2573, extension 25525
Or by e-mail at:
EDIBA@centene.com

Second Opinion

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the LHC network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network and in-network specialty provider types on the prior authorization list will require prior authorization by LHC.

Assistant Surgeon

Reimbursement for an assistant surgeon's service is based on the medical necessity of the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

Clinical Information

Authorization requests may be submitted by fax, phone or secure web portal. Authorization determinations may be communicated to the provider fax, phone, secure email, or secure web portal. Adverse determinations will be followed up in writing. When calling our prior authorization department, a referral specialist will enter demographic information and then transfer the call to a LHC nurse for the completion of medical necessity screening. During heavy call volumes, a nurse may answer the telephone and complete the medical necessity screening during the call. For all services on the prior authorization list, documentation supporting medical necessity will be required.

LHC clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), LHC is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the member.

Information necessary for authorization of covered services may include but is not limited to:

- Member's name, Member ID number
- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g. primary and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate.

If additional clinical information is required, a nurse or medical service representative will notify the caller of the specific information needed to complete the authorization process.

Clinical Decisions

LHC affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. LHC does not reward practitioners or other individuals for issuing denials of service or care.

Delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the LHC Medical Director, is responsible for making utilization management (UM) decisions in accordance with the member's plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

Medical Necessity

Medical necessity is defined for LHC members as healthcare services, supplies or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury
- In accordance with the standards of good medical practice consistent with evidence based and clinical practice guidelines
- Not primarily for the personal comfort or convenience of the member, family, or provider
- The most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member
- Furnished in a setting appropriate to the patient's medical need and condition and, when supplied to the care of an inpatient, further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient service
- Not experimental or investigational or for research or education

Review Criteria

LHC has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 1-xxx-xxx-xxxx. Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted by calling LHC main toll-free phone number and asking for the Medical Director. A case manager may also coordinate communication between the Medical Director and requesting practitioner.

Members or healthcare professionals with the member's consent may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

Louisiana Healthcare Connections
Complaint and Grievance Coordinator
Street Address
City, State Zip
1-xxx-xxx-xxxx
Fax 1-xxx-xxx-xxxx

New Technology

Louisiana Healthcare Connections evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the LHC population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department 1-xxx-xxx-xxxx.

Prior Authorization and Notifications

Prior authorization is a request to the LHC Utilization Management (UM) department for approval of services on the prior authorization list before the service is delivered. Authorization must be obtained prior to the delivery of certain elective and scheduled services. **Prior authorization should be requested at least seven (7) calendar days before the scheduled service delivery date or as soon as need for service is identified**. Services that require authorization by LHC are listed in the Authorization Table. The PCP should contact the UM department via telephone, fax or through our website with appropriate supporting clinical information to request an authorization. All out-of-network services require prior authorization and will require LHC Medical Director review and approval.

Emergency room and post stabilization services never require prior authorization. Providers should notify LHC of post stabilization services such as but not limited to the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery, within one (1) business day of the service initiation. Providers should **notify LHC of emergent inpatient admissions within two (2) business days** of the admission for ongoing concurrent review and discharge planning. Maternity admissions require notification and information on the delivery outcome. Clinical information is required for ongoing care authorization of the service.

Failure to obtain authorization may result in administrative claim denials. LHC providers are contractually prohibited from holding any LHC member financially liable for any service administratively denied by LHC for the failure of the provider to obtain timely authorization.

Authorization Determination Timelines

LHC decisions are made as expeditiously as the member's health condition requires. For standard service authorizations the decision and notification will be made no more than two (2) business days from receipt of necessary medical information (not to exceed a total fourteen (14) calendar days from receipt of the request unless an extension is requested). "Necessary information" includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information can result in an administrative denial of the requested service. For urgent/expedited pre-service requests, a decision and notification is made within seventy-two (72) hours of the receipt of the request. For urgent concurrent review of ongoing inpatient admission and other services such as outpatient rehabilitation, home care or ongoing specialty care decisions are made within 24 hours of receipt of the request. Written or electronic notification includes the number of days of service approved, and the next review date.

Notification of Pregnancy

Members that become pregnant while covered by LHC may remain a LHC member during their pregnancy. The managing physician should notify the LHC prenatal team by completing the Notification of Pregnancy (NOP) form within five (5) days of the first prenatal visit. Providers are expected to identify the estimated date of confinement and delivery facility. The NOP includes an optional prenatal vitamin order form. LHC will facilitate the physician's order of a ninety (90) day supply of prenatal vitamins for the member to be delivered to the managing provider's office by the member's next prenatal visit. See the Case Management section for information related to our Start Smart for Your Baby® Program and our 17-P Program for women with a history of early delivery.

Concurrent Review and Discharge Planning

Nurse Case Managers perform ongoing concurrent review for inpatient admissions through onsite or telephonic methods through contact with the hospital's Utilization and Discharge Planning departments and when necessary, with the member's attending physician. The Case Manager will review the member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within 24 hours of receipt of the request. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or c-section delivery does not require concurrent review, however; the hospital must notify LHC within two (2) business days of delivery with complete information regarding the delivery status and condition of the newborn.

Retrospective Review

Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to LHC was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have their Medicaid card or otherwise indicated Medicaid coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service).

Requests for retrospective review must be submitted promptly. A decision will be made within thirty (30) calendar days following receipt of the request, not to exceed 180 calendar days from the date of service.

SPEECH THERAPY AND REHABILITATION SERVICES

Louisiana HealthCare Connections offers our members access to all covered, medically necessary outpatient physical, occupational and speech therapy services through Cenpatico, Specialty Therapy and Rehabilitative Services (STRS).

Prior authorization for outpatient occupational, physical or speech therapy services should be submitted to Cenpatico STRS using the Outpatient Treatment Request (OTR) form located at www.Cenpatico.com.

Cenpatico STRS Outpatient Therapies Prior Authorization
Fax number 1-855-254-1798

Cenpatico STRS created and applies medical necessity criteria developed using Clinical Practice Guidelines of the physical, occupational and speech Professional Associations, as well as *InterQual* Criteria for both Adults and Pediatrics guidelines. The criteria can be found on the Cenpatico website at: www.Cenpatico.com. Cenpatico STRS utilizes Occupational, Physical and Speech Therapists to process Outpatient Treatment Request. Our specialized approach allows for interaction in real time with the provider to best meet the overall therapeutic needs of the members.

In the event that the practitioner is unable to provide timely access for a member, Cenpatico will assist in securing authorization to a practitioner to meet the member's needs in a timely manner.

For more detailed information about Cenpatico STRS, please visit our website at www.Cenpatico.com.

HI TECH RADIOLOGY SERVICES

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our members, Louisiana Healthcare Connections is using National Imaging Associates (NIA) to provide prior authorization services and utilization. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA
- MRI/MRA
- PET Scan

KEY PROVISIONS:

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ***ordering*** physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

To reach NIA and obtain authorization, please call 1-866-595-8133 and follow the prompt for radiology authorizations. NIA also provides an interactive website which may be used to obtain on-line authorizations. Please visit www.RadMD.com for more information or call our Provider Services department.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service (previously known as Louisiana KIDMED) is Medicaid's comprehensive and preventive child health program for individuals under the age of 21, provision of which is mandated by state and federal law. EPSDT services include periodic screening, vision dental and hearing services. In addition, the need for corrective treatment disclosed by such child health screenings must be arranged (directly or through referral) even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

LHC and its providers will provide the full range of EPSDT services as defined in, and in accordance with, Louisiana state regulations and DHH policies and procedures for EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care. This includes provision of all medically necessary services whether specified in the core benefits and services or not, except those services (carved out/excluded/prohibited services) that have been identified herein. The following minimum elements are to be included in the periodic health screening assessment:

a) Comprehensive health and development history (including assessment of both physical and mental development);
b) Comprehensive unclothed physical examination;
c) Immunizations appropriate to age and health history;
d) Assessment of nutritional status;
e) Laboratory tests (including finger stick hematocrit, urinalysis (dip-stick),sickle cell screen, TB skin testing and RPR serology if not previously performed); Blood lead levels must be tested pursuant to the EPSDT provider manual.
f) Developmental assessment
g) Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses;
h) Dental screening and services coordinated through FFS

i) Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids; and

j) Health education and anticipatory guidance.

Provision of all components of the EPSDT service must be clearly documented in the PCP's medical record for each member.

LHC requires that providers cooperate to the maximum extent possible with efforts to improve the health status of Louisiana citizens, and to actively participate in the increase of percentage of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules. LHC will cooperate and assist providers to identify and immunize all members whose medical records do not indicate up-to-date immunizations.

Provider shall participate in the Vaccines for Children (VFC) program. **Vaccines must be billed with the appropriate administration code and the vaccine detail code.**

EMERGENCY CARE SERVICES

Louisiana Healthcare Connections' defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairments of bodily functions, or (3) serious dysfunction of any bodily organ or part as per 42 CFR 438.114.(a).

Members may access emergency services at any time without prior authorization or prior contact with LHC. If members are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Provider (PCP) and/or LHC' 24 hr Nurse Triage Line (NurseWise) for assistance; however, this is not a requirement to access emergency services. LHC contracts with emergency services providers as well as non-emergency providers who can address the member's non-emergency care issues occurring after regular business hours or on weekends.

Emergency services are covered by LHC when furnished by a qualified provider, including non-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by LHC. Emergency services will cover and reimburse regardless of whether the provider is in LHC' provider network and will not deny payment for treatment obtained under either of the following circumstances:

1. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition; or

2. A representative from the Plan instructs the member to seek emergency services.

Once the member's emergency medical condition is stabilized, LHC requires Notification for hospital admission or Prior Authorization for follow-up care as noted elsewhere in this Manual.

Women's Health Care

LHC will provide direct access to a health specialist in network for core benefits and services necessary to provide women routine and preventive health care services in addition to the member's PCP if the provider is not a women's health specialist. Members are allowed to utilize their own PCP or to any family planning service provider for family planning services without the need for a referral or a prior authorization. In addition, members will have the freedom to receive family planning services and related supplies from an out of network provider without any restrictions. Family planning services include examinations, assessments, traditional contraceptive services, preconception and interconception care services. LHC will make every effort to contract with all local family planning clinic and providers and will ensure reimbursement whether the provider is in or out of network.

VALUE ADDED SERVICES

NurseWise®

Our members have many questions about their health, their primary care provider, and/or access to emergency care. Our health plan offers a nurse line service to help members proactively manage their health needs, decide on the most appropriate care, and encourage members to talk with their physician about preventive care.

NurseWise is our 24 hour, 7 day per week nurse line for members. Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access through the NurseWise service. Our staff often answers basic health questions, but is also available to triage more complex health issues using nationally-recognized protocols. Members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use NurseWise to request information about providers and services available in the community after hours, when the LHC Member Services department ("Member Services") is closed. The NurseWise staff is available in both English and Spanish and can provide additional translation services if necessary.

We provide this service to support your practice and offer our members access to a registered nurse at any time – day or night. If you have any additional questions, please call Provider Services or NurseWise at 1-866-595-8133.

Cent Account Program

The goal of the CentAccount program is to increase appropriate utilization of preventive services by rewarding members for practicing a targeted healthy behavior. The program will strengthen the relationship with the medical home as members regularly access preventive services, and will promote personal responsibility for and ownership of the member's own health care.

CentAccount also benefits members because it provides them with credits to purchase health care items, such as over-the-counter medications that they might otherwise not be able to afford. Services that will qualify for rewards through the program include completion of, annual adult well visits, EPSDT visits, certain disease-specific screenings, and completion of prenatal and postpartum care.

How does it work? Members will receive a prepaid MasterCard® debit card. Credit will be added to the account balance once the member receives certain screenings or preventive care. Members may use the cards to purchase approved health care goods and services online or at more than one hundred fifty (150) retailers that accept MasterCard® Debit cards, such as Wal-Mart, Walgreens, Target, and CVS. CentAccount goods and services are those recognized by the Internal Revenue Service as health care expenses for flexible spending accounts.

CLINICAL PRACTICE GUIDELINES

LHC clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, LHC adopts guidelines that are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field. LHC providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program. Following is a sample of the clinical practice guidelines adopted by LHC.

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health

For links to the most current version of the guidelines adopted by LHC, visit our website at www.LouisianaHealthConnect.com.

CASE MANAGEMENT PROGRAM

LHC case management model is designed to help your LHC members obtain needed services, whether they are covered within the LHC array of covered services, from community resources, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice or large multi-specialty group setting.

The program is based upon a coordinated care model that uses a multi-disciplinary case management team in recognition that a holistic approach yields better outcomes. The goal of our program is to help members achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for disruption at the PCP or specialist office with administrative work.

The program includes a systematic approach for early identification of eligible members, needs assessment, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP. Our case management team will integrate covered and non-covered services and provide a holistic approach to a member's medical, as well as function, social and other needs. We will coordinate access to services not included in core benefit package such as behavioral health, dental and pharmacy services. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A case management team is available to help all providers manage their LHC members. Listed below are programs and components of special services that are available and can be accessed through the case management team. We look forward to hearing from you about any LHC members that you think can benefit from the addition of a LHC case management team member.

To contact a case manager call:

Louisiana Healthcare Connections
Case Management Department
1-xxx-xxx-xxxx

High Risk Pregnancy Program

The OB CM Team will implement our **Start Smart for Your Baby® Program** (Start Smart), which incorporates case management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age. The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing case management to high and moderate risk members through the postpartum period and infants through the first year of life. A case manager with obstetrical nursing experience will serve as lead case manager for members at high risk of early delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead CM for newborns being discharged from the NICU unit and will follow them through the first year of life when they remain members. The OB/Neonate team has physician oversight advising the team on overcoming obstacles, helping identify high risk members, and recommending interventions. These physicians will provide input to LHC Medical Director on obstetrical care standards and use of newer preventive treatments such as **17 alpha-hydroxyprogesterone caproate (17-P**).

LHC offers a premature delivery prevention program by supporting the use of 17-P. When a physician determines that a member is a candidate for 17-P, which use has shown a

substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. This prescription is sent to the LHC case manager who will check for eligibility. The case manager will coordinate the ordering and delivery of the 17-P directly to the physician's office. A prenatal case manager will contact the member and do an assessment regarding compliance. The nurse will remain in contact with the member and the prescribing physician during the entire treatment period. Contact the LHC high risk pregnancy department for enrollment in the 17-P program.

Complex Teams

These teams will be led by clinical licensed nurses with either adult or pediatric expertise as applicable. For both adult and pediatric teams, staff will be familiar with evidence-based resources and best practice standards and experience with the population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services The LHC complex teams will manage care for members whose needs are primarily functional as well as those with such complex conditions as hemophilia, breast/cervical cancer, trauma, organ transplants, and renal dialysis. Foster care members and children with special health care needs are at special risk and are also eligible for enrollment in case management. LHC will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better health care choices.

A **Transplant Coordinator** will provide support and coordination for members who need organ transplants. All members considered as potential transplant candidates should be immediately referred to the LHC case management department for assessment and case management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.

MemberConnections® Program

MemberConnections is LHC outreach program designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our case management program in order to link LHC and the community served. The program recruits staff from the communities serviced to establish a grassroots support and awareness of LHC within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to MemberConnections through numerous sources. Members who phone LHC to talk with LHC Member Services department may be referred for more personalized discussion on the topic they are inquiring about. Case managers may identify members who would benefit from one of the many MemberConnections components and complete a referral request. Providers may request MemberConnections referrals directly to the Connections Representative or their assigned case manager. Community groups may request that a Connections Representative come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Community Connections: Connection Representatives are available to present to group setting during events initiated by state entities, community groups, clinics, or any other

approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what Medicaid coordinated care is all about, overview of services offered by LHCs , how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers and LHC.

Home Connections: Connection Representatives are available on a full-time basis whenever a need or request from a member or provider arises. All home visits are pre-scheduled with the member unless the visit is a result of being unable to locate a member. Topics covered during a home visit include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive health care, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, and how to contact the health plan for assistance.

Phone Connections: Connection Representatives may contact new members or members in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered and any additional questions answered.

Connections Plus®: Connections Representatives work together with the high risk OB team or SSI case management team for high risk members who do not have safe, reliable phone access. When a member qualifies, a Connections Representative visits the member's home and gives them a free, pre-programmed cell phone with limited use. Members may use this cell phone to call the health plan case manager, PCP, specialty physician, NurseWise, 911, or other members of their health care team. In some cases, the plan may provide MP-3 players with pre-programmed education programs for those with literacy issues or in need of additional education.

To contact the MemberConnections Team call:

Louisiana Healthcare Connections
MemberConnections
1-xxx-xxx-xxxx

Chronic Care/Disease Management Programs

As a part of LHC services, Chronic Care Management Programs (CCMP) is offered to members. Chronic Care Management/Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care. Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Nurtur, Centene's disease management subsidiary, will administer LHC chronic care management program. Nurtur's programs promote a coordinated, proactive, disease-specific approach to management that will improve members' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical

conditions. LHC programs include but are not limited to: asthma, diabetes and congestive heart failure.

Not all members having the targeted diagnoses will be enrolled in the CCMP. Members with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk members with co-morbid or complex conditions will be referred for case management program evaluation.

To refer a member for chronic care management call:
Louisiana Healthcare Connections
Health Coach
1-xxx-xxx-xxxx

PROVIDER RELATIONS DEPARTMENT

LHCs' Provider Relations department is designed around the concept of making your experience a positive one by being your advocate within LHC. The Provider Relations Department is responsible for providing the services listed below which include but are not limited to:

- Contracting
- Maintenance of existing LHC Provider Manual
- Capitation distribution
- Eligibility distribution
- Researching of trends in claims inquiries to LHC
- Network performance profiling
- Individual physician performance profiling
- Physician and office staff orientation
- Hospital and ancillary staff orientation
- Ongoing provider education, updates, and training

The goal of the department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to LHC enrolled membership.

To contact the provider relations specialist for your area contact our Provider Services toll free help line at 1-866-595-8133. Provider Services Representatives work with Provider Relations Specialists to serve as your advocates to ensure that you receive necessary assistance and maintain satisfaction with LHC.

Top 10 Reasons to Contact a Provider Relations Representative

1. To report any change to your practice (i.e. practice TIN, name, phone numbers, fax numbers, address, and addition or termination of providers, or patient acceptance.
2. Initiate credentialing of new providers.
3. To schedule an in-service training for new staff.
4. To conduct ongoing education for existing staff.
5. To obtain clarification of policies and procedures.
6. To obtain clarification of a provider contract.
7. To request fee schedule information.

8. To obtain responses to membership list questions.
9. To obtain responses to claims questions.
10. To learn how to use electronic solutions on web authorizations, claims submissions, and check eligibility.

BILLING AND CLAIMS SUBMISSION

General Guidelines

Louisiana Healthcare Connections processes its claims in accordance with applicable State prompt pay requirements.

Physicians, other licensed health professionals, facilities, and ancillary provider's contract directly with Louisiana Healthcare Connections for payment of covered services. It is important that providers ensure Louisiana Connections has accurate billing information on file. Please confirm with your Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

Providers must bill with their NPI number in box 24Jb. We encourage our providers to also bill their taxonomy code in box 24Ja to avoid possible delays in processing. Claims missing the requirements will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered "clean" and therefore cannot be accepted into our system.

We recommend that providers notify Louisiana Connections 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service,
- The service provided is a covered benefit under the member's contract on the date of service, and
- Referral and prior authorization processes were followed, if applicable.

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual and the provider billing manual located at www.LouisianaHealthConnect.com.

Clean Claim Definition

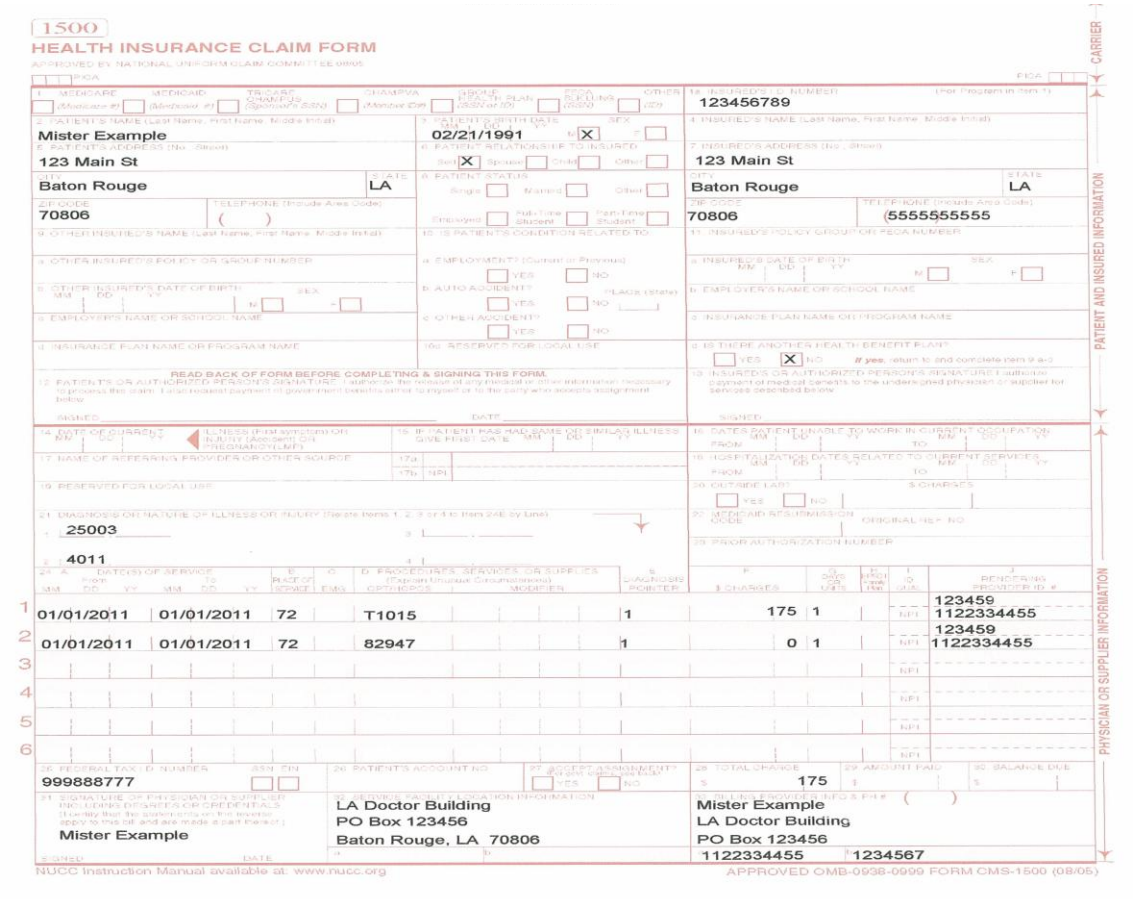
A clean claim is defined as a claim received by Louisiana Healthcare Connections for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of

services in order to be processed by Louisiana Healthcare Connections. The following exceptions apply to this definition: (a) a claim for which fraud is suspected; and (b) a claim for which a Third Party Resource should be responsible.

Non-Clean Claim Definition

A Non-clean claim is defined as a submitted claim that requires further investigation or development beyond the information contained in the claim. The errors or omissions in the claim may result in; a) a request for additional information from the provider or other external sources to resolve or correct data omitted from the claim; b) the need for review of additional medical records; or c) the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

CMS 1500 (HCFA) Claim Example



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]

1a. INSURED'S I.D. NUMBER: 123456789

2. PATIENT'S NAME: Mister Example

3. PATIENT'S BIRTH DATE: 02/21/1991 SEX: M [X] F [ ]

4. INSURED'S NAME:

5. PATIENT'S ADDRESS: 123 Main St

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS: 123 Main St

CITY: Baton Rouge STATE: LA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: Baton Rouge STATE: LA

ZIP CODE: 70806 TELEPHONE: ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 70806 TELEPHONE: 5555555555

9. OTHER INSURED'S NAME:

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 25003

2.

3.

4. 4011

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01/01/2011	01/01/2011	72		T1015		1	175	1		NPI	123459 1122334455
2 01/01/2011	01/01/2011	72		82947		1	0	1		NPI	123459 1122334455
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 999888777 SSN EIN

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 175

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Mister Example

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION:

LA Doctor Building
PO Box 123456
Baton Rouge, LA 70806

a. 1122334455 b.

33. BILLING PROVIDER INFO & PH #: ( )

Mister Example
LA Doctor Building
PO Box 123456

1122334455 1234567

CARRIER

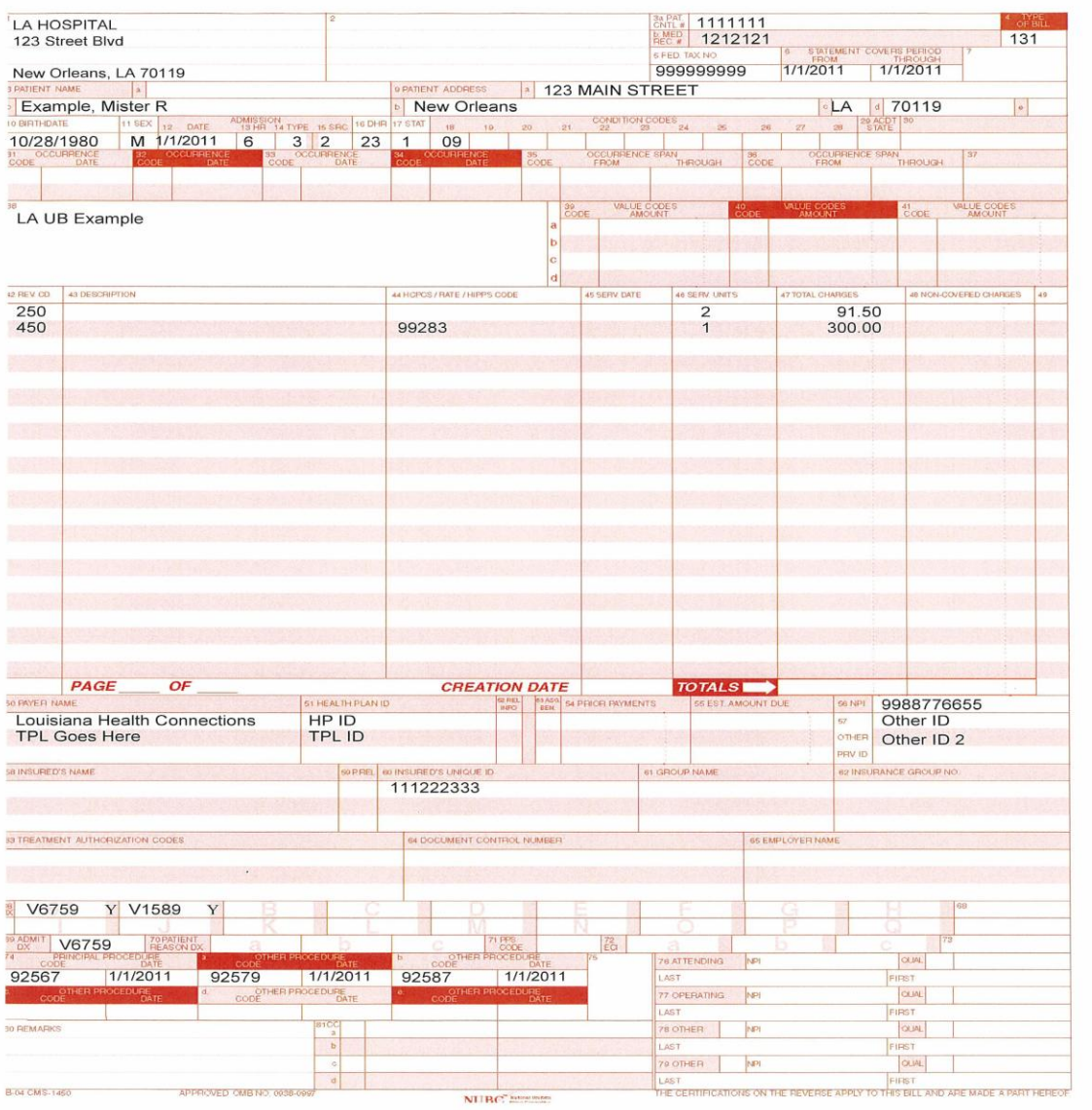
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CMS 1450 (UB-04) Claim Example



Timely Filing

Providers must submit all original claims (first time claims) and encounters to Louisiana Connections within three hundred and sixty five (365) calendar days of the date of service.

All corrected claims, requests for reconsideration or claim disputes must be received within forty five (45) calendar days from the date of notification of payment or denial is issued.

Electronic Claims Submission

Network providers are encouraged to participate in Louisiana Connections' electronic claims/encounter filing program. The plan has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, it has the ability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP).

For more information on electronic filing and what clearinghouses Louisiana Connections has partnered with, contact:

Louisiana Connections
c/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at:
EDIBA@centene.com

Providers that bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Louisiana Healthcare Connections Payer ID is XXXXX and we work with the following clearinghouses:

- Emdeon
- Availity
- Gateway

Paper Claims Submission

All claims and encounters should be submitted to:

INITIAL CLAIMS, CORRECTED CLAIMS and REQUESTS FOR RECONSIDERATION:

Louisiana Connections
ATTN: CLAIMS DEPARTMENT
P.O. BOX 4040
Farmington, MO 63640-3826

CLAIM DISPUTES:
NOTE: Please use the Claim Dispute Form located at www.LouisianaHealthConnect.com

Louisiana Connections
ATTN: CLAIMS DEPARTMENT
P.O. BOX 3000
Farmington, MO 63640-3800

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

Louisiana Connections provides an innovative web-based solution for Electronic Funds Transfers (EFT's) and Electronic Remittance Advices (ERA's). Through this service, providers can take advantage of EFTs and ERAs to settle claims electronically. As a Provider, you can gain the following benefits from using EFT and ERA:

- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying
- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
- Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information, please visit our provider home page on our website at www.louisianahealthconnect.com. If further assistance is needed, please contact Provider Services 1-866-595-8133.

Claim Payment

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- 90% within 15 business days of the receipt
- 99% within 30 calendar days of the receipt

Third Party Liability

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member.

Louisiana Connections is always the payer of last resort. Louisiana Connections providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Louisiana Connections members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform Louisiana Connections that efforts have been unsuccessful. Louisiana Connections will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, Louisiana Connections will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

ENCOUNTERS

What is an Encounter Versus a Claim?

An ***encounter*** is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our members. For example; if you are the PCP for a LHC member and receive a monthly capitation amount for services, you must file an encounter (also referred to as an **"**"proxy claim") on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or "proxy claim" is paid at zero dollar amounts. **It is mandatory that your office submits encounter data.** LHC utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by HFS and by the Centers for Medicare and Medicaid Services (CMS). Encounters do not generate an EOP.

A ***claim*** is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP.

You are required to submit either an encounter or a claim for each service that you render to a LHC member.

Procedures for Filing a Claim/Encounter Data

LHC encourages all providers to file claims/encounters electronically. See the Electronic Claims Submission section and the Provider Billing Manual for more information on how to initiate electronic claims/encounters.

Billing the Member

LHC reimburses only services that are medically necessary and covered through Louisiana's Coordinated Care Network. Providers can bill a member only if they provide proof that they attempted to obtain member insurance identification information within sixty (60) days of service.

Member Acknowledgement Statement

A provider may bill a member for a claim denied as not being medically necessary, not a covered benefit, or the member has exceeded the program limitations for a particular service only if the following condition is met:

Prior to the service being rendered, the provider has obtained and kept a written member acknowledgement statement signed by the client stating,

> ***I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Louisiana's Coordinated Care Network program as being reasonable and medically necessary for my care. I understand that LHC through its contract with the Louisiana Department of Health and Hospitals determines the medical necessity of the services or items that I request and***

receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

For more detailed information on LHC billing requirements, please refer to the Billing Manual available on the website www.LouisanaHealthConnect.com.

CREDENTIALING and RECREDENTIALING

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by the LHC, as well as government regulations and standards of accrediting bodies.

Note: In order to maintain a current provider profile, providers are required to notify LHC if any relevant changes to their credentialing information in a timely manner.

Physicians must submit at a minimum the following information when applying for participation with LHC:

- Complete signed and dated Louisiana Standardized Credentialing application or authorize LHC access to the CAQH (Council for Affordable Quality Health Care
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with Louisiana regulations regarding malpractice coverage or alternate coverage.
- Copy of current Louisiana Controlled Substance registration certificate (if applicable)
- Copy of current Drug Enforcement Administration (DEA) registration Certificate
- Copy of W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of current unrestricted medical license to practice in the state of Louisiana.
- Current copy of specialty/board certification certificate, if applicable
- Curriculum vitae listing, at minimum, a five (5) year work history (not required if work history is completed on the application)
- Signed and dated release of information form not older than one hundred twenty (120) days
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA),if applicable

LHC will verify the following information submitted for Credentialing and/or Re-credentialing:

- Louisiana license through appropriate licensing agency

- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing or alternate admitting arrangements
- Review five (5) year work history
- Review federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General)

Once the application is completed, the LHC Credentialing Committee ("Credentialing Committee") will render a final decision on acceptance following its next regularly scheduled meeting.

Providers must be credentialed prior to accepting or treating members. PCPs cannot accept member assignments until they are fully credentialed.

Credentialing Committee

The Credentialing Committee has the responsibility to establish and adopt as necessary, criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination.

Committee meetings are held at least quarterly and more often as deemed necessary.

***Note**: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.*

Site visits are performed at practitioner offices within sixty (60) days of identification of two or more member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the practitioner's site visit score is less than eighty percent (80%), the practitioner may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices and safety procedures.

Re-Credentialing

To comply with accreditation standards, LHC conducts the re-credentialing process for providers at least every thirty six months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners, primary care providers, specialists, and ancillary providers/facilities previously credentialed to practice within the LHC network.

In between credentialing cycles, LHC conducts ongoing sanction monitoring activities on all network providers. This includes an inquiry to the appropriate Louisiana State Licensing Agency for a review of newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry insures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, LHC reviews monthly reports released by the Office of Inspector General to review for any

network providers who have been newly sanctioned or excluded from participation in Medicare/Medicaid.

A provider's agreement may be terminated if at any time it is determined by the LHC Credentialing Committee that credentialing requirements are no longer being met.

Right to Review and Correct Information

All providers participating within the LHC network have the right to review information obtained by LHC to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the LHC credentialing department. Upon receipt of this information, the provider will have fourteen (14) days to provide a written explanation detailing the error or the difference in information to the. The LHC Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

Right to Be Informed of Application Status

All providers who have submitted an application to join LHC have the right to be informed of the status of their application upon request. To obtain status, contact the LHC Provider Relations department at 1-866-595-8133.

Right to Appeal Adverse Credentialing Determinations

Existing provider applicants who are declined for continued participation for reasons such as quality of care or liability claims issues have the right to request a reconsideration of the decision in writing within fourteen (14) days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the LHC network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than sixty (60) days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two (2) weeks of the final decision.

RIGHTS AND RESPONSIBILITIES

LHC members have the following **rights**:

- To be treated with respect and with due consideration for his/her dignity and privacy.
- To participate in decisions regarding his/her health care, including the right to refuse treatment.

- To complete information about their specific condition and treatment options, regardless of cost or benefit coverage,
- To seek second opinions
- To obtain information about available experimental treatments and clinical trials and how such research can be accessed
- To obtain assistance with care coordination from the PCP's office.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To express a concern or appeal about LHC or the care it provides and receives a response in a reasonable period of time
- To be able to request and receive a copy of his/her medical records, (one copy free of charge) and request that they be amended or corrected.
- To implement an advance directive as required in 42.CFR The right to implement an advance directive as required in 42 CFR§438.10(g)(2)
- To choose his/her health professional to the extent possible and appropriate, in accordance with 42 CFR §438.6(m)
- To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- Freedom to exercise the rights described herein, without any adverse effect on the member's treatment by DHH, LHC, its providers or contractors.
- To receive all information— e.g., enrollment notices, informational materials, instructional materials, available treatment options and alternatives.—in a manner and format that may be easily understood as defined in the Provider Agreement and this Member Handbook
- To receive assistance from both DHH and the Enrollment Broker in understanding the requirements and benefits of LHC.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.

LHC members have the following **responsibilities**:

- To inform LHC of the loss or theft of an ID card
- Present the LHC ID card when using healthcare services
- Be familiar with LHC procedures to the best of the member's abilities
- To call or contact LHC to obtain information and have questions clarified
- To provide participating network providers with accurate and complete medical information
- Following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible;

- To make every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services.
- To live healthy lifestyles and avoid behaviors known to be detrimental.
- To provide accurate and complete information to all health care providers.
- To become knowledgeable about LHC coverage provisions, rules and restrictions.
- To ask questions of providers to determine the potential risks, benefits, and costs of treatment alternatives, and then making care decisions after carefully weighing all pertinent factors
- To follow the grievance process established by LHC (and outlined in the Member Handbook) if there is a disagreement with a provider.

Provider Rights

LHC providers have the **right** to:

- Be treated by their patients and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for members' care
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly
- Expect other network providers to act as partners in members' treatment plans
- Expect members to follow their directions, such as taking the right amount of medication at the right times
- Make a complaint or file an appeal against Louisiana Healthcare Connections and/or a member
- File a grievance with Louisiana Healthcare Connections on behalf of a member, with the member's consent
- Have access to information about Louisiana Healthcare Connections quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
- Contact Louisiana Healthcare Connections Provider Services with any questions, comments, or problems,
- Collaborate with other healthcare professionals who are involved in the care of members

Provider Responsibilities

LHC providers have the **responsibility** to:

- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments
    - Provide information regarding the nature of treatment options
    - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may self administered

    - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options
- Treat members with fairness, dignity, and respect
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow members to request restriction on the use and disclosure of their personal health information
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
- Respect members' advance directives and include these documents in the members' medical record
- Allow members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions
- Allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately
- Follow all state and federal laws and regulations related to patient care and patient rights
- Participate in Louisiana Healthcare Connections data collection initiatives, such as HEDIS and other contractual or regulatory programs
- Review clinical practice guidelines distributed by Louisiana Healthcare Connections
- Comply with Louisiana Healthcare Connections Medical Management program as outlined in this manual.
- Disclose overpayments or improper payments to Louisiana Healthcare Connections
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
- Obtain and report to Louisiana Healthcare Connections information regarding other insurance coverage
- Notify Louisiana Healthcare Connections in writing if the provider is leaving or closing a practice

- Contact Louisiana Healthcare Connections to verify member eligibility or coverage for services, if appropriate
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language
- Not be excluded, penalized, or terminated from participating with Louisiana Healthcare Connections for having developed or accumulated a substantial number of patients in the Louisiana Healthcare Connections with high cost medical conditions
- Coordinate and cooperate with other service providers who serve Medicaid members such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships and school based programs as appropriate
- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds
- Disclose to Louisiana Healthcare Connections, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between Louisiana Healthcare Connections and the physician or physician group

GRIEVANCES AND APPEALS PROCESS

Member Grievances and Provider Complaints

A member grievance is defined as any member expression of dissatisfaction about any matter other than an "adverse action". A provider complaint is any provider expression of dissatisfaction about any matter other than a claims dispute. ***Note**: Throughout the manual, we will consider the term "grievance" to refer to both member grievances and provider complaints as the resolution processes are the same. Provider complaints include disputes regarding policies, procedures or any aspect of LHC administrative functions including proposed actions.*

The grievance process allows the member, (or the member's authorized representative (family member, etc.) acting on behalf of the member or provider acting on the member's behalf with the member's written consent), to file a grievance either orally or in writing. The member will be allowed thirty (30) calendar days from the date of notice of action or inaction to file a grievance or appeal. LHC shall acknowledge receipt of each grievance in the manner in which is received. Any individuals who make a decision on grievances will not be involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, LHC shall ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the member's condition or disease. [42 CFR § 438.406] LHC values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member's behalf. LHC will provide assistance to both members and providers with filing a grievance by contacting our Member/Provider Services Department at XXX-XXX_XXXX.

Acknowledgement

Staff receiving grievances orally will acknowledge the grievance and attempt to resolve them immediately. Staff will document the substance of the grievance. For informal grievances, defined as those received orally and resolved immediately to the satisfaction of the member, representative or provider, the staff will document the resolution details. Member notification of the grievance resolution shall be made in writing within two (2) business days of the resolution. The Complaint and Grievance Coordinator (CGC) will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within five (5) business days of receipt.

Grievance Resolution Time Frame

Grievance Resolution will occur as expeditiously as the member's health condition requires, not to exceed thirty (30) calendar days from the date of the initial receipt of the grievance. Grievances will be resolved by the CGC, in coordination with other LHC staff as needed. In our experience, most grievances are resolved at the staff level to the satisfaction of the member, representative or provider filing the grievance. Expedited grievance reviews will be available for members in situations deemed urgent, such as a denial of an expedited appeal request, and will be resolved within seventy-two (72) hours.

Notice of Resolution

The CGC will provide written resolution to the member, representative or provider within the timeframes noted above. The letter will include the resolution and DHH requirements, including the right to a second level review by the Grievance Appeal Committee (GAC) if the member is not satisfied.

The grievance response shall include, but not be limited to, the decision reached by Louisiana Healthcare Connections, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the enrollee. A copy of verbal complaints logs and records of disposition or written grievances shall be retained for six (6) years.

Grievances may be submitted by written notification to:

Louisiana Healthcare Connections
Complaint and Grievances Coordinator (CGC)
Street Address
City, State, Zip
1-xxx-xxx-xxxx

Appeals

An appeal is the request for review of a "Notice of Adverse Action". A "Notice of Adverse Action" is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service excluding technical reasons; the failure to render a decision within the required timeframes; or the denial of a member's request to exercise his/her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the LHC network. The review may be requested in writing or orally, however oral requests for

appeals within the standard timeframe must be resolved within thirty (30) days of receipt of the appeal, with a fourteen (14) day extension possible if additional information is required. Members may request that LHC review the Notice of Adverse Action to verify if the right decision has been made.

Expedited Appeals

Expedited appeals may be filed when either LHC or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding seventy-two (72) hours from the initial receipt of the appeal. LHC may extend this timeframe by up to an additional fourteen (14) calendar days if the member requests the extension or if LHC provides evidence satisfactory to the DHH that a delay in rendering the decision is in the member's interest. For any extension not requested by the member, LHC shall provide written notice to the member of the reason for the delay. LHC shall make reasonable efforts to provide the member with prompt verbal notice of any decisions that are not resolved wholly in favor of the member and shall follow-up within two (2) calendar days with a written notice of action.

Written notice shall include the following information:

a) The decision reached by LHC;
b) The date of decision;
c) For appeals not resolved wholly in favor of the member the right to request a State fair hearing and information as to how to do so; and
d) The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the LHC decision.

Call or mail all appeals to:
Louisiana Healthcare Connections
Complaint and Grievances Coordinator (CGC)
Street Address
City, State and Zip
1-xxx-xxx-xxxx

State Fair Hearing Process

LHC will include information in the Member Handbook, online and via the appeals process to members of their right to appeal directly to the DHH. The member has the right to appeal to the DHH at the same time that they appeal to LHC, after exhausting appeal rights with LHC, or instead of appealing to LHC.

Any adverse action or appeal that is not resolved wholly in favor of the member by LHC may be appealed by the member or the member's authorized representative to the DHH for a fair hearing conducted in accordance with 42 CFR § 431 Subpart E. Adverse actions

include reductions in service, suspensions, terminations, and denials. LHC denial of payment for Louisiana Medicaid covered services and failure to act on a request for services within required timeframes may also be appealed. Appeals must be requested in writing by the member or the member's representative within thirty (30) days of the member's receipt of notice of adverse action unless an acceptable reason for delay exists. An acceptable reason shall include, but not be limited to, situations or events where:

- Appellant was seriously ill and was prevented from contacting LHC
- Appellant did not receive notice of the LHC decision
- Appellant sent the request for appeal to another government agency in good faith within in the time limit
- Unusual or unavoidable circumstances prevented a timely filing
- Additionally, if LHC notice is "defective,"(i.e., does not contain the required elements), cause may exist

For member appeals, LHC is responsible for providing to the DHH and to the member an appeal summary describing the basis for the denial. For standard appeals, the appeal summary must be submitted to the DHH and the member at least ten (10) calendar days prior to the date of the hearing. For expedited appeals, (that meet the criteria set forth in 42 CFR § 438.410) the appeal summary must be faxed to the DHH and faxed or overnight mailed to the member, as expeditiously as the member's health condition requires, but no later than four (4) business hours after the DHH informs LHC of the expedited appeal. The DHH may require that LHC attend the hearing either via telephone or in person.

LHC shall comply with the DHH's fair hearing decision. The DHH's decision in these matters shall be final and shall not be subject to appeal by LHC.

Reversed Appeal Resolution

In accordance with 42 CFR §438.424, if the LHC or the state fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, LHC will authorize the disputed services promptly and as expeditiously as the member's health condition requires. Additionally, in the event that services were continued while the appeal was pending, LHC will provide reimbursement for those services in accordance with the terms of the final decision rendered by the DHH and applicable regulations.

To File A Medicaid State Hearing:

The Office of Appeal Hearings
Street Address
City, State, Zip
1-xxx-xxx-xxxx

WASTE, FRAUD AND ABUSE

Waste Abuse and Fraud (WAF) System

LHC takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a waste, abuse and fraud (WAF) program that complies with Louisiana and federal

laws. LHC, in conjunction with its management company, Centene, successfully operates a waste, abuse and fraud unit. LHC performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system; please review the Billing and Claims section of this manual. The Special Investigation Unit (SIU) performs retrospective audits which, in some cases, may result in taking actions against those providers, individually or as a practice, commit waste, abuse, and/or fraud. These actions include but are not limited to:

- Remedial education and/or training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

Some of the most common WAF practices include:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of Benefits
- Claims for services not rendered

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential WAF hotline at 1-866-685-8664. LHC and Centene take all reports of potential waste, abuse or fraud very seriously and investigate all reported issues.

Please Note: *Due to the evolving nature of wasteful, abusive and fraudulent billing, LHC and Centene may enhance the WAF program at any time. These enhancements may include but is not limited to creating, customizing or modifying claim edits, upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of adherent billing patterns.*

Authority and Responsibility

The LHC Director of Regulatory Affairs & Compliance has overall responsibility and authority for carrying out the provisions of the compliance program. LHC is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The LHC provider network will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

QUALITY IMPROVEMENT

LHC culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

LHC recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, LHC will provide for the delivery of quality care with the primary goal of improving the health status of its members. Where the member's condition is not amenable to improvement, LHC will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the LHC QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

Program Structure

The LHC Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BOD oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Assessment and Performance Improvement Committee (QAPIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the QI, UM, and Credentialing programs.

The following sub-committees report directly to the Quality Assessment and Performance Improvement Committee:

- Credentialing Committee
- Grievance and Appeals Committee
- Utilization Management Committee
- CLAS Task Force
- Performance Improvement Team

- Member, Provider and community advisory committees
- Joint Operations Committees
- Peer review Committee (Ad Hoc Committee)

Practitioner Involvement

LHC recognizes the integral role practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. LHC encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as but not limited to, the QAPIC, Credentialing Committee and select ad-hoc committees.

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to the LHC members. Louisiana Healthcare Connections' QAPI Program incorporates all demographic groups, care settings, and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, long-term care (depending upon the product), and ancillary services, and operations.

LHC primary QAPI Program goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

To that end, the LHC QAPI Program monitors the following:

- Compliance with preventive health guidelines and practice guidelines
- Acute and chronic care management
- Provider network adequacy and capacity
- Selection and retention of providers (credentialing and recredentialing)
- Behavioral healthcare (within benefits)
- Delegated entity oversight
- Continuity and coordination of care
- Utilization Management, including under and over utilization
- Compliance with member confidentiality laws and regulation
- Employee and provider cultural competency
- Provider appointment availability
- Provider and Health Plan after-hours telephone accessibility
- Member satisfaction
- Provider satisfaction
- Member grievance system
- Provider complaint system
- Member enrollment and disenrollment
- PCP changes
- Department performance and service
- Patient safety

- Marketing practices

Patient Safety and Quality of Care

Patient Safety is a key focus of LHC QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member. LHC employees (including medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential quality of care issues. Adverse events may also be identified through claims based reporting. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

LHC QAPIC reviews and adopts an annual QAPI Program and Work Plan based on managed care Medicaid appropriate industry standards. The QAPIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or the service.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Louisiana Healthcare Connections to monitor improvement over time.

Annually, LHC develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QAPIC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QAPIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

LHC communicates activities and outcomes of its QAPI Program to both members and providers through avenues such as the member newsletter, provider newsletter and the LHC web portal at www.louisanahealthconnect.com .

At any time, LHC providers may request additional information on the health plan programs including a description of the QAPI Program and a report on LHC's progress in meeting the QAPI Program goals by contacting the Quality Improvement department.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the Louisiana State Medicaid contract.

As both the Louisiana and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. Louisiana purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company's ability to demonstrate an improvement in preventive health outreach to its members. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an increased premium based on scoring of such quality indicators used in HEDIS.

How are HEDIS rates calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews (see LHCs' website and HEDIS brochure for more information on reducing HEDIS medical record reviews). Measures typically requiring medical record review include: childhood immunizations, well child visits, diabetic HbA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

Who will be conducting the Medical Record Reviews (MRR) for HEDIS?

Louisiana Healthcare Connections will contract with a national MRR vendor, to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, you may receive a call from a medical record review representative if any of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Louisiana Healthcare Connections which allows them to collect PHI on our behalf.

What can be done to improve my HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as diabetes, eye exam and blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at 1-xxx-xxx-xxxx.

Provider Satisfaction Survey

LHC conducts an annual provider satisfaction survey which includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and provider services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by LHC, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well we are meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

Provider Profiling and Incentive Programs

Over the past several years, it has been nationally recognized that pay-for-performance (P4P) programs, which include provider profiling, have emerged as a promising strategy to improve the quality and cost-effectiveness of care. LHC currently uses a pay-for-performance program that includes physician profiling to improve care and services provided to LHC members.

The P4P program promotes efforts that are consistent with the Institute of Medicine's aims for advancing quality (safe, beneficial, timely, patient-centered, efficient and equitable) as well as recommendations from other national agencies such as the CMS-AMA Physician Consortium, NCQA and NQF. Additionally, LHC will provide an opportunity for financial reward to PCPs and specialists using an incentive payment that encourages accurate and timely submission of preventive health and disease monitoring services in accordance with evidence-based clinical practice guidelines.

The goals of LHC P4P program are:

- Increase provider awareness of his/her performance in key areas
- Motivate providers to establish measurable performance improvement processes relevant to LHC member populations in their practices
- Use peer performance data and/or other established benchmarks to identify outlier provider practices that reflect best practices or less than optimal performance
- Increase opportunities for LHC to partner with providers to achieve measurable improvement in health outcomes by developing, implementing, and monitoring practice-based performance improvement initiatives

LHC will accomplish these goals by:

- Producing and distributing provider-specific reports containing meaningful, reliable, and valid data for evaluation by LHC and the provider.
- Creating incentives for provider implementation of practice-based performance improvement initiatives that are pertinent to LHC member populations linked with adopted evidence-based clinical practice guidelines and that yield measurable outcomes.
- Establishing and maintaining an open dialogue with profiled providers related to performance improvement.

Physicians, meeting a minimum panel threshold, will receive a quarterly profile report with an individual score for each measure. Scores will be benchmarked per individual measure and compared to the LHC network average and as applicable, to the then available NCQA Quality Compass Medicaid mean. Provider profile indicator data is not risk adjusted and scoring is based on provider performance within the service area range.

PCPs who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by Louisiana Healthcare Connections in publications such as newsletters, bulletins, press releases, and recognition in our provider directories as well as being eligible for applicable financial incentive programs. Additionally, LHC offers several financial incentive programs such as claim based incentive programs. More information on our incentive programs can be found on the provider web portal or by contacting LHC Contracting and/or Provider Relations departments.

MEDICAL RECORDS REVIEW

Medical Records

LHC providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable LHC to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. LHC requires providers to maintain all records for members for at least six (6) years. See the Member Rights section of this manual for policies on member access to medical records.

Required Information

Medical records means the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail.
- All entries must be dated and signed, or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Sunshine Health's practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and
- ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed and drug administered or dispensed including instructions to the member.

- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried).
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older.

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned LHC members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record.

Medical Records Audits

LHC will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. LHC will provide written notice prior to conducting a medical record review.

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